Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: SPINE HOSPITAL OF SOUTH TEXAS 18600 HARDY OAK BLVD SAN ANTONIO TX 78258-4206	MFDR Tracking #:	M4-05-2074-01
Respondent Name and Box #: City of San Antonio Box #: 42		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The Carrier provided individual payment exception codes of 'M' for each line item of billed charges. However, several of the billed charges had a maximum allowable reimbursement per the TWCC Fee Guidelines and were not reimbursed by the Carrier for the 'MAR' amounts."… "In this instance, the Carrier did not provide any documentation of a developed or consistently applied methodology, which was used in reducing payment for the treatment/service in question. The healthcare provider charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $416.57
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: The respondent did not submit a position statement for consideration.

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
7/16/2004	M, W	Outpatient Surgery	$416.57	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code M – "Payment is reduced form the billed amount for treatment/service for which TWCC has not set a maximum allowable reimbursement."; and W – "Carrier refused payment of bull [sic] pursuant to Texas Administrative Code, rule 134.801(C): A health care provider shall not submit a medical bill later than the first day of the eleventh month after the date of services are provided." Review of the documentation finds that the carrier EOB in payment of the original bill states "received date

7/29/2004". Review of the request for reconsideration finds that the requestor has provided convincing evidence of carrier receipt in the form of a fax transaction report dated "2004/OCT/26/TUE" sufficient to establish that the provider submitted the request in a timely manner. The Division therefore concludes that neither the original bill nor the request for reconsideration were submitted to the insurance carrier later than the first day of the eleventh month after the date the services were provided in accordance with §134.801(c). Denial code W is therefore not supported.

2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division Rule at 28 TAC §134.1, 27 TexReg 4047 (May 10, 2002) which requires that "reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011"…
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. The requestor's position statement asserts that "The Carrier provided individual payment exception codes of 'M' for each line item of billed charges. However, several of the billed charges had a maximum allowable reimbursement per the TWCC Fee Guidelines and were not reimbursed by the Carrier for the 'MAR' amounts."… "Therefore, the Carrier's application of 'M' for each billed item is not in accordance with the Texas Administrative Code and the Commission's instructions and the requestor is entitled, at the minimum to the fee guideline reimbursement amount for billed items which have a 'MAR' per the TWCC Fee Guideline." Review of the provider bills and medical records for the disputed services finds that the services performed were ambulatory/outpatient surgical care as addressed in 28 TAC §134.401(a)(4) effective August 1, 1997, which states in part that these services are "not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements." Review of the disputed services finds that none of the disputed services has a MAR. The provider's request for fee guideline reimbursement for billed items which have a MAR is therefore not supported.
5. The Division notes that the requestor submitted additional information for consideration received August 30, 2007 in the form of a "Procedure Analysis – Detail" report showing average reimbursement rates that the provider was paid for procedure code 64483 by various carriers posted between dates 10/1/03 – 01/01/05. Although the requestor states "We would like to submit the attached additional information to substantiate our case regarding fair and reasonable reimbursement"…, the requestor does not discuss or explain how the submitted documentation supports the request for additional reimbursement as required by 28 TAC §133.307(g)(3)(C)(iv), 27 TexReg 12282 . Review of the additional documentation finds that the provider received payment from the US Department of Labor averaging 45% of billed charges. Review of the insurance carrier payment for the services in this dispute finds that the provider received $1,050.00 in payment of billed charges totaling $2,095.10 representing a 51% reimbursement, which is greater than the average amount that the provider documents that it was paid by the US Department of Labor for similar services during the time frame of the report. Review of the additional information submitted by the requestor finds that the report does not support that payment of the amount sought would meet the requirements of Texas Labor Code §413.011(d) which states, in part, that "The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf."
6. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines)". The requestor's position statement asserts that "The healthcare provider charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services."… However, review of the "Procedure Analysis – Detail" report submitted by the requestor finds that the requestor has not documented any example of reimbursement at the full amount of the provider's billed charges. The Division notes that out of 34 instances of payment for similar services during the time frame of the report, the requestor documents payment at reimbursement amounts that are less than the billed charges in every instance. The requestor's assertion that "The healthcare provider charges the above referenced services at a fair and reasonable rate" is therefore not supported.
7. The requestor further asserts that "The methodology utilized by the healthcare provider was created to ensure that similar procedures provide in similar circumstances receive similar reimbursement from Carriers." However, the requestor does not further discuss or explain the methodology, or how the specific charges were determined. Nor does the requestor discuss or explain how the proposed reimbursement meets the specific criteria set forth in §413.011(d). Thorough review of the documentation submitted by the requestor finds that the requestor has not supported, demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.